| OFFICE USE ONLY | |
|---|---|
| Cleared by Travel Nurse | |
| Cleared by Manager | |
| Certificate Issued | |

# HEALTHCARE ELECTIVE TRAVEL RISK ASSESSMENT

UEA MEDICAL SERVICES – TRAVEL HEALTH CENTRE

## SECTIONS 1-3 TO BE COMPLETED BY STUDENT (in advance of appointment)

### (1) PERSONAL DETAILS

| | | |
|---|---|---|
| **Name:**<br><br>**DOB:** | | **E-mail:**<br><br>**Contact Number(s):** |
| **Address:** | **Male / Female** *(delete as applicable)* | **GP Name & Address:** |

### (2) ELECTIVE TRAVEL PLANS

| Travelling to: | Date: | Describe location (rural/city/jungle…) |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |

**What do you plan to do on your elective/placement?**

### (3) ADDITIONAL TRAVEL PLANS

**Do you plan on travelling anywhere either before or after your elective?**

☐ Yes
☐ No

**If yes - where?** (please state all countries)

## SECTIONS 4-9 TO BE COMPLETED BY TRAVEL HEALTH NURSE

### (4) MEDICAL HISTORY

**Current:**

**Previous:**

**Current Medication:**

**Allergies:**

**Any Allergic Reaction to Egg or Gelatine:**
☐ Yes
☐ No

**Any problem with vaccines?**
☐ Yes
☐ No

**FEMALE TRAVELLERS ONLY**

**Is there any risk of pregnancy?**
☐ Yes
☐ No

**Is patient planning a pregnancy?**
☐ Yes
☐ No

**LMP Date ……**

### (5) MALARIA PROPHYLAXIS

☐ Bite Avoidance
☐ Repellents
☐ Clothing
☐ Nets
☐ Prophylaxis
☐ S/S Malaria

**Previous Malaria Prophylaxis?**
☐ Yes
☐ No

**Which** ……

**Any Problems?**
☐ Yes
☐ No

**Script Issued Date:**

……

**Issued by:**

……

**Signature:**

……

**Does patient have a history of:**
☐ Epilepsy
☐ Psoriasis
☐ Kidney/Liver Problems
☐ Asthma
☐ Diabetes
☐ Immunosuppression
☐ Steroid Therapy
☐ Anxiety/Depression

### (6) PSD AUTHORISATION STATEMENT

Following completion of the Travel Risk Assessment, I hereby authorise the use of the recommended vaccines below as a Patient Specific Direction (PSD).

**Dr Name: ……** **Dr Signature: ……** **Date: ……**

**HIV Incidence in elective countries:**

**Script Issued Date:** .....

**Issued by:** ..... **Signature:** .....

**Possible contraindications to any vaccines/malaria prophylaxis:**

## (7) IMMUNISATIONS

| BCG date: | MMR dates: | Last DTP: | Hep B dates: | Comments |
|---|---|---|---|---|
| | 1. | | 1. | |
| | | | 2. | |
| | 2. | Booster | 3. | |
| | | | 4. | |

| Consider | Required | Vaccine | Dates given previously | Date given in Travel clinic | Batch No. site and signature |
|---|---|---|---|---|---|
| ☐ | ☐ | BCG Vaccine | | | |
| ☐ | ☐ | DTP (Diphtheria, Tetanus, Polio) | | | |
| ☐ | ☐ | Hepatitis A Primary/Booster | | | |
| ☐ | ☐ | Typhoid | | | |
| ☐ | ☐ | Meningitis ACWY | | | |
| ☐ | ☐ | Rabies 1st | | | |
| ☐ | ☐ | Rabies 2nd | | | |
| ☐ | ☐ | Rabies 3rd | | | |
| ☐ | ☐ | Yellow Fever | | | |
| ☐ | ☐ | Japanese Encephalitis 1st | | | |
| ☐ | ☐ | Japanese Encephalitis 2nd | | | |
| ☐ | ☐ | Others | | | |

## (8) VACCINATION SCHEDULE

| | | | |
|---|---|---|---|
| | | | |
| | | **Additional Vaccines/Requirements/Notes:** | |

## (9) COMMENTS/ADDITIONAL INFORMATION

| | | |
|---|---|---|
| Date: | | Signed: |
| Date: | | Signed: |
| Date: | | Signed: |
| Date: | | Signed: |

**PATIENT CONSENT**

I consent to this vaccine programme, and fully acknowledge that it is my responsibility to check on Rabies and HIV post-exposure treatment availability in relation to the elective upon which this risk assessment is based.

**Patient Signature ..... Date .....**

Nurse signature .....

Date of Risk assessment .....